Welcome to our practice!
Grand Traverse Allergy
1115 S. Union St, Traverse City, MI 49684
Phone: (231) 995-3657 Fax: (231) 995-3658
Please Print Clearly

Patient Name _____ **Date of Birth**_____ M____ F____

Mailing Address _____

City _____ **State** _____ **Zip Code** _____

Marital status: (circle one) Minor S M W D **Patient's Social Security No.** _____

Billing Address (if different from above) _____

City_____ State_____ Zip Code_____ Home

Responsible Party (if different than Patient) _____ **Date of Birth** ____/_____/_____

Relationship to Patient _____**Social Security# Of Responsible Party:** _____-_____-_____

Phone_____ Is it okay to leave a detailed message? Yes No

Cell Phone_____ Is it okay to leave a detailed message? Yes No

Email Address_____

Is it okay to send confidential health information via e-mail? Yes No

Employer _____ **Work Phone** _____

Emergency Contact Person _____ Phone No. _____

Relationship to Patient (for Emergency Contact Person) _____

Primary Care Physician _____ Phone No. _____

Preferred Pharmacy _____ Phone No. _____

ANY KNOWN DRUG ALLERGIES:

_____

_____

If the patient is under 18 years of age, please complete the following:

Father's Name _____ Lives with child? Yes No
Employer _____ Work Phone No. _____
Mother's Name _____ Lives with child? Yes No
Employer _____ Work Phone No. _____

INSURANCE INFORMATION

Primary Insurance: _____

ID #. _____ Group # _____

(Fill out the following information if the patient is not the card-holder)

Cardholder_____ **Relationship** _____

Birth Date _____ Social Security No. _____
(May be necessary to file insurance)

If you have additional insurance, please complete the following:

Insurance Co. _____

ID # _____ Group # _____

(Fill out the following information if the patient is not the card-holder)

Card-holder _____ **Relationship** _____

Birth Date _____ Social Security No. _____
(may be necessary to file insurance)

Ethnicity:

Primary Language : **English** **Spanish** **Other:** _____	**Latino or Hispanic** **Not Hispanic or Latino** **Decline to specify**	**Race:** **Native American/ Alaskan Native** **African American or Black** **White** **Asian** **Other** **Decline to Specify**

Please list below any family members for friends that you would like Grand Traverse Allergy to share Medical information with if they where to call and ask.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____